Appendix A. Definitions

Active Case of Tuberculosis -- also referred to as a new verified case of tuberculosis. These cases are characterized by (1) any bacteriological confirmation of the presence of Mycobacterium tuberculosis or (2) in the absence of bacteriological confirmation, for a diagnosis of active pulmonary tuberculosis the patient must present a positive purified protein derivative (PPD), or must exhibit a positive chest x-ray, or in the case of children, must be epidemiologically linked to another active case of tuberculosis. In the case of extrapulmonary tuberculosis, the patient must show signs of clinical improvement while taking tuberculosis medication.

Ambulatory Care Sensitive (ACS) Conditions -- those for which timely and effective primary care could have reduced the risk of hospitalization. In some cases, this care could prevent the onset of an illness or condition; in others it could help control an acute episode or manage a chronic condition.

Birth Weight -- the first weight of the fetus or newborn obtained after delivery.

Cause of Death Classification -- a system of specification of the diseases and/or injuries which led to death and the sequential order of their occurrence. The version of the system in use since 1999 is the *International Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10), sponsored by the World Health Organization

ICD-10 –- the *International Classification of Diseases and Related Health Problems, Tenth Revision*. See Appendix F for more information about ICD-10.

Infant Death – a death within the first year of life.

Life Expectancy -- the expected number of years to be lived, on average, by persons born in the year analyzed.

Live Birth -- the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Low Birth Weight -- birth weight of less than 2,500 grams or approximately 5 pounds, 8 ounces.

Motor Vehicle-Related Injuries -- Motor vehicle-related injury is a broad term encompassing a number of different types of motorized vehicles and a variety of circumstances covering an encounter of an individual with a motorized vehicle. A motor vehicle is defined in *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, Volume 1* as "any mechanically or electrically powered device, not operated on rails, upon which any person or property may be transported or drawn upon a highway. Any object such as a trailer, coaster, sled, or wagon being towed by a motor vehicle is considered a part of the motor vehicle." The Manual includes automobile; bus; construction, industrial, or farm machinery; fire engine; motorcycle; moped; motorized scooter; trolley bus not operating on rails; truck; and van in its definition of motor vehicle. Persons killed or injured by a motor vehicle can be

drivers, passengers, bicyclists, or pedestrians. Injuries and fatalities related to the use of motor vehicles are not currently labeled “accidents” by public health professionals, as these events are considered preventable.

Stages of Syphilis (Larsen and Kraus, 1990): **Primary Syphilis** -- begins within approximately 30 hours after infection; a primary chancre usually forms within two through six weeks of infection. Both treponemal and nontreponemal antibodies appear one through four weeks after the lesion has formed. Even without treatment, the lesion usually resolves within two months. **Secondary Syphilis** -- occurs within six weeks of healing of the primary lesion. Disseminated lesions appear that are attributable to systemic infection. Virtually every organ and tissue of the body is affected. Whether treated or untreated, the lesions of secondary syphilis usually resolve within two through ten weeks.

State of the Art Tools to Detect Newborn Hearing Loss -- The current state of the art is the use of electrophysiologic screening measures, which are the electrical result of the application of physiologic agents and includes, but is not limited to, the procedures currently known as Auditory Brainstem Response testing (ABR) and Otoacoustic Emissions testing (OAE). Auditory Brainstem Response (ABR) means a physiologic measure used for detecting unilateral or bilateral hearing loss by measuring the activity of the cochlea, auditory nerve, and auditory brainstem pathways. Otoacoustic Emission (OAE) means a physiologic measure used for detecting unilateral or bilateral hearing loss by measuring the responses generated within the cochlea by the outer hair cells. Either Distortion Product Otoacoustic Emissions (DPOAE) or Transient Evoked Otoacoustic Emissions (TEOAE) may be used. OAE evaluation does not detect neural dysfunction.

Trimester of Pregnancy -- the first trimester includes the first 12 weeks of pregnancy, the second trimester encompasses the thirteenth through twenty-fourth weeks, and the third trimester is the period after the twenty-fourth week through delivery.

Underlying Cause of Death -- the disease or injury which initiated the train of events leading directly to death or the circumstances of the unintentional injury or violence which produced the fatal injury.

Appendix B. Rates and Ratios

The presentation of statistics in the form of rates and ratios facilitates comparisons between political subdivisions with populations of different sizes or between subgroups of a population. Crude rates are calculated by dividing the number of events of a type that occur to the residents of an area (e.g., births or deaths divided by the resident population of an area or subgroup). The events are limited to those that occur within a specific time period, usually a year, and the population is, in general, the mid-year estimate of the resident population of the area, although census counts as of April 1 may be used in decennial census years. Crude rates are expressed in terms of occurrences within a standard, rounded population, usually 1,000 or 100,000.

While the denominators for rates consist of the population at risk of the events included in the numerator (e.g., births, deaths), ratios are designed to indicate the relationship between two counts in which the denominator population is not at risk of the events included in the numerator.

In order to compare natality, mortality, and morbidity experience among various ages and races or between the sexes, rates may be computed for subgroups of the population. These are referred to as age-, race-, or sex-specific rates and are calculated by dividing the relevant events within a subgroup by the population in the subgroup. Death rates from specific causes may also be calculated, with the numerator consisting of the deaths from the particular cause in an area and the denominator comprised of the population at risk of the disease or condition.

The definitions of rates and ratios used in this report follows. It should be noted that alternative forms exist for some of these statistics. Some other states and the federal government may employ different formulae for the computation of selected rates.

Age-Adjusted Incidence or Death Rate –- the application of age-specific rates to a standard population to arrive at the theoretical number of events that would occur in the standard population at the rates prevailing in the actual population. The number of events is divided by the total number of persons in the standard population to arrive at the adjusted rate. The resulting age-adjusted rate is an index number and can only be compared to other rates age-adjusted using the same standard population and cannot be compared to crude or other actual rates. The standard population used in this report for age-adjustment of rates is the United States 2000 standard million, derived from projected 2000 decennial census counts.

Age-Specific Birth Rate -- the number of resident live births to females in a specific age group per 1,000 females in the age group.

Cause-Specific Death Rate -- the number of resident deaths from a specific cause per 100,000 population.

Crude Death Rate -- the number of resident deaths per 100,000 population.

Crude Incidence Rate -- the number of newly diagnosed cases per 100,000 population within a given time span, usually one year.

Infant Mortality Rate -- the ratio of the number of deaths to children less than one year of age in a given year per 1,000 births in the same year.

Years of Potential Life Lost (YPLL) Rate -- a measure used to reflect the trends in premature mortality. YPLL represents the summation of all of the years of life not lived to a defined upper limit. For this document, the YPLL age limit is set at 65. Deaths at younger ages receive a greater weight in computing YPLL than do deaths at older ages, e.g., one death at age 20 adds 45 years to YPLL, while a death at age 64 adds only one year to YPLL. Thus the death of one 20 year old is equivalent to the deaths of 45 persons aged 64 in the computation of years of potential life lost. The YPLL rate is the total YPLL in years, divided by the appropriate population under the age of 65.

Caution should be exercised in the interpretation of rates and ratios based on small numbers.

Mortality rates based on fewer than 20 deaths do not meet National Center for Health Statistics (NCHS) standards for reliability and precision and therefore have been suppressed throughout this document.

Appendix C. Sampling Error

Data based on a small number of observations tend to be unreliable and may vary dramatically from year to year. This is true for data which are the result of complete counts, as well as those obtained through sampling of a larger population. In addition to random variation, survey data are subject to sampling errors, which are expressed as standard errors (s.e.'s). Standard errors are available only for selected estimates used as baseline data for objectives included in *Healthy New Jersey 2010*. Estimates from the New Jersey Behavioral Risk Survey (NJBRFS) have standard errors provided, while the health insurance coverage estimates from the Current Population Survey and the estimates of tobacco, drug and alcohol use from the respective surveys of middle and high school students have not had standard errors computed.

Standard errors tend to be larger for estimates based on small sample sizes. When responses from the total sample are subdivided into smaller subgroups, the resulting estimates for the smaller subgroups, in particular, may be based on a small number of responses. In this document, estimates which use the New Jersey Behavioral Risk Factor Survey as the data source have been marked with two asterisks or replaced by three asterisks when the standard error exceeded the following criteria:

NJBRFS Estimate	Flag (Two Asterisks)	Suppression (Three Asterisks)
5%	s.e. > 1.0%	s.e. > 2.5%
10%	s.e. > 1.0%	s.e. > 4.0%
20%	s.e. > 1.5%	s.e. > 5.5%
30%	s.e. > 2.0%	s.e. > 6.0%
40%	s.e. > 2.0%	s.e. > 6.0%
50%	s.e. > 2.0%	s.e. > 6.0%
60%	s.e. > 2.0%	s.e. > 6.0%
70%	s.e. > 2.0%	s.e. > 6.0%
80%	s.e. > 1.5%	s.e. > 5.5%
90%	s.e. > 1.0%	s.e. > 4.0%
95%	s.e. > 1.0%	s.e. > 2.5%

For example, an estimate from the NJBRFS of 40 percent of respondents who reported a particular health behavior would be marked with two asterisks if the standard error exceeded 2.0 percent and suppressed with three asterisks if the standard error was more than 6.0 percent. Estimates from the NJBRFS that fall between the stated estimates in the chart would be interpolated between the adjacent categories. For example, an estimate of 25 percent would receive two asterisks if its s.e. exceeded 1.75 percent and three asterisks if its s.e. was more than 5.75 percent. The criteria in the table were derived in part from criteria used by the National Household Survey of Drug Abuse conducted in 1994. Caution should be exercised when drawing conclusions for those estimates with relative standard errors exceeding the above limits.

Appendix D. ICD-10 Codes for Cause-Specific Mortality Objectives

Objective Number	Cause of Death	ICD-10 Codes
3B-2	SIDS (Sudden Infant Death Syndrome)	R95
3C-5	Homicide	X85-Y09, Y87.1
3C-6	Homicide by Firearms	X93-X95
3F-1	Motor Vehicle Related Injuries	V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V79, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86, V87.0-V87.8, V88.0-V88.8, V89.0, V89.2
3F-3	Motor-Vehicle Related Pedestrian Deaths	V02.1, V02.9, V03.1, V03.9, V04.1, V04.9, V09.2
3F-4	Falls	W00-W19
4A-1	Coronary Heart Disease	I11, I20-I25
4A-2	Cerebrovascular Disease	I60-I69
4B-1	Diabetes	E10-E14
4B-2	Cardiovascular Disease in the presence of diabetes	Underlying cause: I00-I78 Contributing cause: E10-E14
4C-1	Female Breast Cancer	C50 (female only)
4C-4	Cervical Cancer	C53
4C-7	Prostate Cancer	C61
4C-8	Colorectal Cancer	C18-C21
4C-11	Lung Cancer	C33-C34
4D-8	HIV Infection	B20-B24
4E-2	Suicide	X60-X84, Y87.0
4F-1	Drug-Related	F11.0-F11.5, F11.7-F11.9, F12.0-F12.5, F12.7-F12.9, F13.0-F13.5, F13.7-F13.9, F14.0-F14.5, F14.7-F14.9, F15.0-F15.5, F15.7-F15.9, F16.0-F16.5, F16.7-F16.9, F17.0, F17.3-F17.5, F17.7-F17.9, F18.0-F18.5, F18.7-F18.9, F19.0-F19.5, F19.7-F19.9, X40-X44, X60-X64, X85, Y10-Y14
4F-2	Tobacco-Related	See Appendix E
4F-3	Alcohol-Related	See Appendix E
4G-1	Asthma	J45-J46

Cause of death refers to the underlying cause of death unless otherwise noted.

Appendix E. Tobacco- and Alcohol-Related Mortality

Objectives 4F-2 and 4F-3 in the Addictions chapter use algorithms developed by the Centers for Disease Control and Prevention (CDC) to estimate the number of deaths attributable to tobacco and alcohol use. There are no causes of death directly attributable to tobacco and only fifteen which are directly attributable to alcohol, but tobacco and alcohol are at the root of many other conditions which eventually lead to death. The Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) and Alcohol-Related Disease Impact (ARDI) algorithms involve applying smoking- and alcohol-attributable fractions, respectively, to deaths due to certain causes. For some causes of death, the fractions used in the algorithms are constant (e.g., 40% of liver cirrhosis deaths are attributable to alcohol use) while others vary with prevalence of smoking and drinking in a population. Annual prevalence data were obtained from the New Jersey Behavioral Risk Factor Survey (NJBRFS). Underlying cause of death data from New Jersey's annual death files were used. For more information on the algorithms and their methodology, including relative risk estimates, smoking-attributable and alcohol-attributable fractions, and causes of death and ICD-10 codes:

- Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): http://apps.nccd.cdc.gov/sammec/

  For *Healthy New Jersey 2010*, only the Adult SAMMEC portion was used.

- Alcohol-Related Disease Impact (ARDI): http://www.cdc.gov/alcohol/index.htm

  For *Healthy New Jersey 2010*, alcohol-attributable fractions were based on medium and high average daily alcohol consumption.

Appendix F. Changes in Baselines, Targets, and Preferred Endpoints for Mortality and Cancer Incidence Objectives

Two major changes took effect nationally in the reporting of mortality and cancer incidence beginning with 1999 data. As of January 1, 1999, all mortality data are classified according to the tenth revision of the *International Classification of Diseases and Related Health Problems* (ICD-10). ICD-10 changes not only how causes of death are grouped for tabulation and ranking, but also how the underlying cause of death is determined from the multiple causes listed on the death certificate. This leads to breaks in trend lines when 1999 deaths are compared with previous years. Also, beginning with 1999 data, age-adjusted mortality and cancer incidence rates are computed using the estimated 2000 U.S. population as a standard, which replaces the 1940 and 1970 U.S. standard populations used, respectively, in previous years.

When the baseline data for *Healthy New Jersey 2010* were prepared, 1998 was the most recent year for which mortality and cancer incidence data were available. Therefore, targets and preferred endpoints were set based on 1998 baseline data which was coded under the ninth revision of the *International Classification of Diseases* (ICD-9) and age-adjusted using the 1940 and 1970 standard populations, respectively.

In order to update the mortality and cancer incidence objectives, targets and endpoints needed to be reset to reflect these changes. Since the cancer incidence objectives were only affected by the change in standard population, the 1998 baseline rates were recomputed and new targets and preferred endpoints were recalculated such that the percent changes in the original document were maintained. Mortality objectives were not only affected by the change in standard population for age-adjusted rates, but also by the change to ICD-10. In order to make death data coded under ICD-9 comparable to data coded under ICD-10, comparability ratios are applied to weight the older data. It was decided that rather than applying the comparability ratios to the 1998 baseline data, 1999 would be used as the baseline year for mortality objectives. New targets and endpoints were then calculated which maintained the percent changes from the original *Healthy New Jersey 2010* document.

Appendix G. Population Data Used in the Calculation of Rates

Population estimates used to calculate various rates in this report were derived from the files of bridged-race intercensal and postcensal population estimates prepared by the National Center for Health Statistics (NCHS) in collaboration with the U.S. Bureau of the Census. These estimates result from bridging the 31 race categories used in the 2000 Census, as specified in the 1997 federal OMB standards for the collection of data on race and ethnicity, to the four race categories specified under the 1977 standards. Many data systems are continuing to use the 1977 standards during the transition to full implementation of the 1997 standards. Intercensal estimates were used with 1996-1999 data, estimates as of April 1, 2000 were used with 2000 data, and Vintage 2002 estimates were used with 2001 and 2002 data. For more information about the bridged-race population estimates:
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm

The estimates presented below have not been rounded. However, it should not be presumed that they have the degree of accuracy which such precise figures might imply.

Bridged-Race Population Estimates, New Jersey, 2000-2002

Age Group	Total	Male	Female	White	White Non-Hispanic	Black	Black Non-Hispanic	Hispanic	Asian/ Pacific Islander
2000									
< 5	563,785	288,085	275,700	420,540	334,491	100,230	89,341	99,371	40,618
5-14	1,195,106	612,271	582,835	896,091	733,740	219,620	199,395	187,002	74,561
15-24	1,005,295	515,648	489,647	746,974	576,072	186,178	167,181	194,460	67,479
25-34	1,189,040	591,904	597,136	889,217	699,273	194,465	175,976	213,141	100,406
35-44	1,435,106	708,291	726,815	1,130,037	964,024	203,047	187,880	184,971	97,164
45-54	1,158,898	561,202	597,696	942,266	839,224	144,331	134,887	114,738	68,911
55-64	753,984	358,632	395,352	619,399	558,184	94,818	90,318	66,795	37,883
65-74	574,669	254,197	320,472	495,708	461,662	59,673	57,310	36,959	18,191
75-84	402,468	153,851	248,617	364,912	350,810	29,597	28,660	15,270	7,420
85+	135,999	38,732	97,267	124,686	120,492	9,510	9,271	4,484	1,640
Total	8,414,350	4,082,813	4,331,537	6,629,830	5,637,972	1,241,469	1,140,219	1,117,191	514,273
2001									
< 5	563,228	287,518	275,710	417,813	326,850	102,608	90,796	104,958	40,670
5-14	1,209,526	619,240	590,286	905,719	735,861	222,188	201,313	195,415	76,495
15-24	1,026,974	527,196	499,778	764,366	592,871	190,363	171,476	195,036	67,376
25-34	1,157,539	577,804	579,735	857,546	658,670	190,189	171,280	222,828	104,625
35-44	1,447,871	715,009	732,862	1,131,448	951,600	207,668	191,584	200,131	103,644
45-54	1,201,505	582,590	618,915	971,525	860,572	150,928	140,764	123,667	75,346
55-64	786,219	373,532	412,687	644,616	579,032	97,647	92,707	71,730	42,007
65-74	566,804	251,600	315,204	484,319	448,174	60,785	58,288	39,252	20,587
75-84	407,914	156,712	251,202	367,865	352,220	30,833	29,808	16,935	8,632
85+	143,539	41,919	101,620	131,527	126,672	9,784	9,526	5,178	2,036
Total	8,511,119	4,133,120	4,377,999	6,676,744	5,632,522	1,262,993	1,157,542	1,175,130	541,418
2002									
< 5	567,489	289,478	278,011	417,344	321,505	106,394	93,430	110,797	41,873
5-14	1,215,159	622,232	592,927	907,399	732,350	222,798	201,570	201,193	79,700
15-24	1,037,777	532,256	505,521	772,622	602,845	191,990	173,428	192,988	68,230
25-34	1,133,575	567,395	566,180	833,417	627,866	187,501	168,404	229,945	107,362
35-44	1,451,167	716,481	734,686	1,126,919	936,215	210,569	193,695	212,073	108,359
45-54	1,233,476	598,958	634,518	992,652	874,120	156,619	145,924	132,005	80,256
55-64	830,460	394,507	435,953	681,146	611,762	101,441	96,041	76,138	45,760
65-74	561,101	249,744	311,357	475,693	437,562	61,757	59,177	41,358	22,499
75-84	411,176	158,584	252,592	369,435	352,318	31,727	30,623	18,511	9,391
85+	148,923	44,292	104,631	136,329	130,936	9,995	9,737	5,725	2,373
Total	8,590,303	4,173,927	4,416,376	6,712,956	5,627,479	1,280,791	1,172,029	1,220,733	565,803

Appendix H. Race and Ethnicity

Race and ethnicity are reported as separate characteristics on some of the forms used to collect data for health objectives in this document. Among these are the birth and death certificates, the Electronic Birth Certificate, the NJBRFS questionnaire, the UB-92 hospital discharge file, and the Cancer Registry. Other data systems collect race/ethnicity as one characteristic: non-Hispanic white, non-Hispanic black, non-Hispanic other race, and Hispanic. These data systems include the surveys of middle and high school drug, alcohol, and tobacco use; the HIV registry; and the communicable disease data. The STD program has available data only for white and non-white races.

In order to address the overall goal of eliminating health disparities, baselines for relevant objectives were presented for race/ethnicity groups and other high-risk populations, in addition to the total population. Where the data were available, 2010 targets were set for the total population, non-Hispanic whites, non-Hispanic blacks, Hispanics, and Asian and Pacific Islanders. Where Hispanic or Asian/Pacific Islander data were not available, only the total population, whites (including Hispanics), and blacks (including Hispanics) have 2010 targets and will be tracked through the decade.

Data derived from birth certificates are presented by race and ethnicity of the mother. The reporting of Hispanic ethnicity on some of the other major data systems is problematic due to a large percentage of records with ethnicity not stated. Efforts are underway to improve the reporting of Hispanic ethnicity and for Asian and Pacific Islanders on the health data collected by the New Jersey Department of Health and Senior Services (NJDHSS), but, for this document, a number of the objectives appear without baseline data for these two populations. In those cases where steps have been taken or are planned which will provide or improve the reporting of these groups, the appropriate objectives have included Hispanics and Asian/Pacific Islanders as target populations, but no data are given. In those cases where data for Hispanics and Asian/Pacific Islanders are presented, caution should be exercised in using these rates, as they may understate the true rates.

Appendix I. Data from the New Jersey Health Plan Employer Data and Information Set (HEDIS)

The health maintenance organization (HMO) data presented in this report were derived by one of two methods: a review of billing records (the administrative method) or an examination of both medical and administrative records (the hybrid method). Use of the administrative records method will result in lower rates. HEDIS rates are based on complex protocols and documentation requirements to demonstrate that a patient has received a particular service.

Comparisons between HEDIS and population-based measures in *Healthy New Jersey 2010* are complicated by differences in applicable age groups and time frames. HEDIS data are collected on persons enrolled in New Jersey HMOs and Point of Service plans including commercial and self-insured products (but excluding Medicare and Medicaid). Specific definitions for the HEDIS measures contained in this report and the corresponding *Healthy New Jersey 2010* measures are:

Immunizations:

HEDIS is based on the full range of immunizations (4 diphtheria/pertussis/tetanus (DPT), 3 polio, 1 measles/mumps/rubella, 3 influenza type b, 3 hepatitis B, and 1 chicken pox) by the time of the second birthday. Completion by the age of two is strictly adhered to and the patient record must include the antigen and date given.

Healthy New Jersey 2010's data on childhood immunization are obtained from quarterly surveys conducted by the Centers for Disease Control and Prevention (CDC) of the immunization status of children 18 through 35 months of age.

Dilated Eye Exams of Persons with Diabetes:

HEDIS data are for persons aged 31 or older with diagnosed diabetes who received an eye exam from an eye care specialist during the past year.

Healthy New Jersey 2010 uses findings from the New Jersey Behavioral Risk Factor Survey (NJBRFS) on persons 18 and over with diagnosed diabetes who report having had a dilated eye exam within the past year.

Mammograms:

HEDIS reports mammograms done on women aged 52 through 69 during the previous two years.

Healthy New Jersey 2010's measure in this area is estimated from NJBRFS results for women 40 and over who report receiving a clinical breast examination and a mammogram within the past two years.

Appendix J. Data from the 2000 New Jersey Occupational Health Surveillance Program Survey of New Jersey Hospitals

Latex sensitization allergy is an emerging occupational health problem. Latex exposure primarily occurs from the use of gloves and other medical products. Though natural rubber latex (NRL) has proven effective in preventing transmission of many infectious diseases, the use of NRL gloves has also contributed to documented sensitization to NRL allergens among 1 to 6 percent of the general population and 7 to 17 percent of health care workers.[1] Symptoms from exposure to latex may be severe and result in serious health problems.

In 2000, the New Jersey Department of Health and Senior Services (NJDHSS) Occupational Health Surveillance Program convened a Latex Allergy Task Force to provide guidance and advice to NJDHSS regarding the prevention and management of NRL sensitization and allergy. The Task Force developed guidelines entitled " Management of Natural Rubber Latex Allergy: Selecting the Right Glove for the Right Task in Health Care Facilities" which were distributed to health care facilities to assist them in management of latex sensitization. Sections in the guidelines suggest policies on patient care, employee related issues, and evaluation and recommendations for use of gloves. For **patient care**, guidelines indicate that patients diagnosed with NRL allergy should not have any contact with NRL products and recommend NRL screening upon hospital admission, referrals to allergists to determine specific sensitivities, protocols for educating staff and patients about NRL allergies, and the establishment of NRL–safe areas of the hospital. In terms of **employee health,** similar specifications were outlined including instituting employee-education programs, encouraging employees to report allergies to supervisors, and providing affected employees with NRL-safe products with which to perform their work responsibilities. The Latex Allergy Task Force also suggests that health care facilities reduce the use of NRL gloves where appropriate alternatives can be substituted. Preventive actions include the evaluation of allergen levels in NRL gloves and **selection of non-powdered gloves** to reduce the risk of sensitization and allergy and the potential consequences.[1] The guidelines are available on the NJDHSS Division of Epidemiology, Environmental and Occupational Health's Occupational Health Surveillance Program web site: http://www.state.nj.us/health/eoh/survweb/latexgui.pdf

The Occupational Health Surveillance Program also conducted a survey in 2000 to assess New Jersey hospital facilities' adherence to the guidelines. Baseline data were collected through a survey of a sample of 122 New Jersey hospitals. A list of hospitals was obtained from the NJDHSS' Division of Health Planning and a survey with a cover letter requesting completion of the survey was mailed to hospitals. A follow-up mailing was sent to non-responders of the first mailing. Hospitals were asked to provide the information requested on a voluntary basis. Overall 34 percent of the hospitals surveyed completed the questionnaire.

Among the hospitals completing the questionnaire, the percentage having a policy regarding prevention of latex allergy is as follows:

Patient care policy	90% (95% confidence interval (81%, 99%))
Employee health policy	76% (95% confidence interval (63%, 89%))
Selection of glove policy	41% (95% confidence interval (26%, 56%))

1. Management of Natural Rubber Latex Allergy: Selecting the Right Glove for the Right Task in Health Care Facilities, NJDHSS Division of Epidemiology, Environmental and Occupational Health's Occupational Health Surveillance Program web site: http://www.state.nj.us/health/eoh/survweb/latexgui.pdf

Appendix K. Data Sources

Data from birth and death certificates provide the measurement of achievement for a number of the objectives encompassed by *Healthy New Jersey 2010*. Birth certificates are usually completed by hospital personnel, while death certificates are prepared by hospital personnel, physicians, medical examiners, and funeral directors. New Jersey law requires that certificates of all births and deaths which occur in the state must be filed with the Local Registrar within a specified time period after occurrence. The certificates are then submitted to the office of the State Registrar, where they are recorded and filed permanently.

For public health planning and policy determination, the most useful population to study is usually the resident population of an area. For the objectives comprising *Healthy New Jersey 2010* which use birth and death data to measure progress, the data presented are for New Jersey residents. The National Center for Health Statistics sponsors a program of resident certificate exchange among the registration areas in the country, which fosters transfer of information on events occurring to out-of-state residents to the state of residence. This is particularly important to New Jersey, as a number of births to female residents of this state and deaths of New Jersey residents occur in New York and Pennsylvania.

Data on morbidity and disease incidence contained in this report come from a number of sources. Within the New Jersey Department of Health and Senior Services (NJDHSS), these include the New Jersey cancer registry, the AIDS registry, and the Office of Communicable Disease Service in the Department's Division of Epidemiology, Environmental, and Occupational Health. Reporting of data from these systems is residence-based and includes data on New Jersey residents diagnosed in other states. Discharges from New Jersey acute care hospitals are reported through the Uniform Billing (UB-92) data system. The resulting data files serve as the source of information on the diagnoses and demographic characteristics of persons hospitalized in the state. For objectives which employ hospitalization rates as measures, the UB-92 file was used to provide occurrence-based baseline data.

Survey data from several sources were used to provide data for measurement of selected objectives: various health behaviors (the New Jersey Behavioral Risk Factor Survey); smoking and drug use among middle school public and private school students (The New Jersey Middle School Survey on Substance Use); and health insurance coverage (the Current Population Survey). Many of the Divisions within NJDHSS collect and analyze data specific to objectives contained in *Healthy New Jersey 2010*. These include environmental and occupational health data provided by the Division of Environmental and Occupational Health Services; core functions of local health departments provided by the Office of Local Health; data from the Women, Infants, and Children Program collected by the Division of Family Health Services; data on funds expended for nursing home and home or community-based long-term care services supplied by the Divisions of Consumer Support and Senior Affairs; and selected health indicators on managed care enrollees from the Health Plan Employer Data and Information Set (HEDIS) provided through the Division of Health Care Quality & Oversight.

Several other departments within New Jersey state government with health-related responsibilities participated in the development of *Healthy New Jersey 2010* and have provided objectives with baseline data related to these areas of responsibility. Among the source files for data from other departments are three from the Division of Mental Health Services of the

New Jersey Department of Human Services: the Unified Services Transaction Form, Crisis Intervention Service Reports, and Bureau of Licensing Reports of the Office of Children's Services Designation Reports. The Department of Law and Public Safety provides data on alcohol-related motor vehicle fatalities from the Fatal Accident Reporting System and data on drug, alcohol, and tobacco use among public high school students from the report, "Drug and Alcohol Use Among New Jersey High School Students." In addition to other state government departments, outside agencies provided data for objectives in this document: the Trans-Atlantic Renal Council provided data on characteristics of persons with newly diagnosed End Stage Renal Disease, and the New Jersey Institute of Technology is the source of information on local health department LINCS participation.

Included in the set of objectives which comprise *Healthy New Jersey 2010* are a number which have been labeled as developmental. These objectives have no existing baseline data. To be included in this document, these objectives had to have data currently in the process of being collected or have a collection system planned for implementation early in this decade. Among the developmental data sets which are expected to provide data for this process are the Elementary School, Grade Eight, and High School Proficiency Assessments from the Office of Standards and Professional Development in the Division of Academic Programs and Standards of the New Jersey Department of Education and the Minimum Data Set being collected by the Division of Senior Affairs of NJDHSS. In addition, the Office of Local Health of NJDHSS is planning extensive data collection efforts among local health departments to provide measurement on progress toward meeting objectives related to the functioning of local health departments.

Healthy NJ 2010 Objectives by Data Source

Objective Number	Health Measure	Data Source
1. Overall Health Status		
1	Years of Potential Life Lost	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
2	Life Expectancy at Birth	
3	Self-Reported Health Status	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
4	Days Able To Do Usual Activities	
2. Access to Health Care		
1, 2	Health Insurance	Current Population Survey Bureau of the Census, US Department of Commerce Contact: Center for Health Statistics, NJDHSS
3	Source of Primary Care	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
4	Dental Visits	

5	Hospital Admissions for Ambulatory Care Sensitive Conditions	Uniform Billing Patient Summary Division of Health Care Quality & Oversight, NJDHSS Center for Health Statistics, NJDHSS
3A. Environmental Health		
1, 2	Air Quality	Consumer and Environmental Health Services, NJDHSS New Jersey Department of Environmental Protection
3	Radon	
4	Drinking Water	
5	Beach Closings	
6	Hazardous Waste Sites	
7	Residential Lead Evaluations	
8	Retail Food Establishment Deficiencies	
3B. Healthy Mothers and Young Children		
1, 2	Infant Mortality	New Jersey Resident Matched Infant Death/Birth Certificate File Center for Health Statistics, NJDHSS
3, 4	Birth Weight	New Jersey Resident Birth Certificates Center for Health Statistics, NJDHSS
5, 6	Prenatal Care	
7, 8	Breastfeeding	New Jersey Electronic Birth Certificates Family Health Services, NJDHSS
9	Alcohol and Tobacco Use During Pregnancy	New Jersey Resident Birth Certificates Center for Health Statistics, NJDHSS
10	WIC Program	WIC Services Family Health Services, NJDHSS
11	Childhood Vaccines	National Immunization Survey Centers for Disease Control and Prevention, US Department of Health and Human Services Contact: Vaccine Preventable Disease Program Division of Communicable Diseases, NJDHSS and Health Plan Employer Data and Information Set Division of Health Care Quality & Oversight, NJDHSS
12	NJ Immunization Registry	Vaccine Preventable Disease Program, NJDHSS
13	Measles Incidence	Vaccine-Preventable Diseases Program Communicable Disease Services, NJDHSS
14, 15	Lead Screening	Division of Family Health Services, NJDHSS
16	Newborn Hearing Screening	New Jersey Electronic Birth Certificates Division of Family Health Services, NJDHSS
17, 18	Newborn Hearing Screening Follow-up	Division of Family Health Services, NJDHSS
19	Elementary School Proficiency Assessment	Office of Standards and Professional Development Division of Academic Programs and Standards New Jersey Department of Education
3C. Healthy Behaviors - Adolescents		
1	Grade Eight Proficiency Assessment	Office of Standards and Professional Development Division of Academic Programs and Standards

2	High School Proficiency Assessment	New Jersey Department of Education
3, 5, 6, 7	Substance Use Among Middle School Students	"The New Jersey Middle School Survey on Substance Use" Research and Information Systems Division of Addiction Services NJ Department of Human Services
4, 8	Substance Use Among High School Students	"Drug and Alcohol Use Among New Jersey High School Students" Division of Criminal Justice NJ Department of Law and Public Safety
9	Teen Births	New Jersey Resident Birth Certificates Center for Health Statistics, NJDHSS
10, 11	Teen Homicides	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
3D. Healthy Behaviors - Adults		
1	Daily Consumption of Fruits and Vegetables	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
2, 3	Overweight and Obesity	
4	Participation in Physical Activity	
5, 6	Homicides	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
3E. Occupational Health and Safety		
1	Construction Industry Deaths	Occupational Health Services, NJDHSS
2	Blood Lead Exposure	
3	Latex-Allergy Prevention	
4	Hepatitis B Vaccinations	
5	Musculoskeletal Injuries	
3F. Unintentional Injury		
1, 3	Motor-Vehicle Related Deaths	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
2	Seat Belt Usage	New Jersey Department of Law and Public Safety, Division of Highway and Traffic Safety New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
4	Fall-Related Deaths	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
5	Traumatic Brain Injuries	Traumatic Brain Injury Surveillance System Center for Health Statistics, NJDHSS
3G. Preserving Good Health for Seniors		
1	Nursing Home/Home and Community Based Services Spending Ratio	Division of Aging and Community Services, NJDHSS

2-4	Vaccinations of Non-Institutionalized Seniors	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
3-4	Vaccinations of Institutionalized Seniors	Minimum Data Set Long Term Care Systems, NJDHSS
5	Falls in Long Term Care Facilities	
6	Decubitus Ulcer Prevalence	
7	Polypharmacy	
8	Hip Fractures	Uniform Billing Patient Summary Division of Health Care Quality & Oversight and Center for Health Statistics, NJDHSS
4A. Heart Disease and Stroke		
1, 2	Coronary Heart Disease Deaths	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
2	Cerebrovascular Disease Deaths	
3	Blood Cholesterol Checks	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
4B. Diabetes		
1, 2	Diabetes and Cardiovascular Disease Deaths	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
3	Diabetes Screening	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
4	Blood Pressure Control	
5	Dilated Eye Exam	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS and Health Plan Employer Data and Information Set Division of Health Care Quality & Oversight, NJDHSS
6	Lower Extremity Amputations	Uniform Billing Patient Summary Division of Health Care Quality & Oversight and Center for Health Statistics, NJDHSS New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
7	End-Stage Renal Disease	Family Health Services, NJDHSS
8	Glycosylated Hemoglobin Measurement	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
4C. Cancer		
1, 4, 7, 8, 11	Cancer Deaths	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
2	Clinical Breast Exam and Mammogram	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS and Health Plan Employer Data and Information Set Division of Health Care Quality & Oversight, NJDHSS
3	Early Diagnosis of Breast Cancer	New Jersey Cancer Registry, NJDHSS

5	Pap Test	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
6, 9, 12	Cancer Incidence	New Jersey Cancer Registry, NJDHSS
10	Fecal Occult Blood Test/Sigmoidoscopy	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
13	Late Diagnosis of Oral Cancer	New Jersey Cancer Registry, NJDHSS
4D. HIV/AIDS		
1	Receive Test Results	HIV/AIDS Services, NJDHSS
2-5, 7	HIV Incidence	
6	HIV Positive Readings in Mothers of Newborns	
8	HIV Deaths	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
4E. Mental Health		
1	Good Mental Health Days	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
2	Suicides	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
3	Non-emergency, Inpatient Psychiatric Hospital Admissions	Unified Services Transactions Form Division of Mental Health Services NJ Department of Human Services
4	Readmissions to Children's Crisis Intervention Services	Crisis Intervention Service Reports Division of Mental Health Services NJ Department of Human Services
5	Parent Participation in Site Reviews of Youth Programs	Bureau of Licensing Reports of the Office of Children's Services Designation Reports Division of Mental Health Services NJ Department of Human Services
6	Criminal Justice System Mental Health Services	Unified Services Transaction Form Division of Mental Health Services NJ Department of Human Services
4F. Addictions		
1	Drug-Related Deaths	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
2	Tobacco-Related Mortality	New Jersey Resident Death Certificates and New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) Centers for Disease Control and Prevention US Department of Health and Human Services
3	Alcohol-Related Mortality	New Jersey Resident Death Certificates and New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS Alcohol-Related Disease Impact (ARDI) Centers for Disease Control and Prevention US Department of Health and Human Services

4	Alcohol-Related Motor Vehicle Injury Deaths	Fatal Accident Reporting System Division of Highway Traffic Safety NJ Department of Law and Public Safety
5	Cigarette Smoking Prevalence	New Jersey Behavioral Risk Factor Survey Center for Health Statistics, NJDHSS
6	Alcohol Consumption	
4G. Asthma		
1	Asthma Deaths	New Jersey Resident Death Certificates Center for Health Statistics, NJDHSS
2, 3	Asthma Hospitalizations	Uniform Billing Patient Summary Division of Health Care Quality & Oversight and Center for Health Statistics, NJDHSS
4	Asthma Emergency Department Visits	Division of Health Care Quality & Oversight, NJDHSS
4H. Infectious Diseases		
1	Tuberculosis Incidence	Communicable Disease Service, NJDHSS
2	Tuberculosis Curative Therapy	
3	Lyme Disease Incidence	
4I. Sexually Transmitted Diseases		
1, 2	Chlamydia Trachomatis Incidence	Communicable Disease Service, NJDHSS
3	Gonorrhea Incidence	
4, 5	Syphilis Incidence	
5. Strengthening Public Health Capacity		
1	Data Release Within One Year	Health Information Steering Committee, NJDHSS
2	Standardized Geocoding	Office of Information Technology Services, NJDHSS
3	Race/Ethnicity Tracking	Center for Health Statistics, NJDHSS
4	Public Use Files	Health Information Steering Committee, NJDHSS
5	Core Functions	Office of Local Health, NJDHSS
6	Community Health Plan Development	
7a	Local Health Department Internet Access	Survey of Local Health Department Information Technologies, Office of Local Health, NJDHSS
7b	LINCS Participation	New Jersey Institute of Technology
8	Staffing Standards	Office of Local Health, NJDHSS
9	Public Health and Environmental Laboratory Standards	
10	Epidemiology Services Standards	